United States of America

Naval Consolidated Brig Miramar

Sexual Offender Treatment Program Evaluation & Development Project

PHASE II: PROGRAM DEVELOPMENT DESCRIPTION OF CHANGES

Central Coast Clinical & Forensic Psychological Services, Inc.

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Table of Contents

Executive Summary

Central Coast Clinical and Forensic Psychology Services (CCCFP) is independently contracted by the US Federal Government to conduct a project to evaluate and update the US Naval Consolidated Brig Miramar (NAVCON BRIG Miramar) Sexual Offender Treatment Program (SOTP) in San Diego, California. This report marks the midpoint of the second and final phase of the project. The primary members of the CCCFP project collaborative, Drs. D'Orazio, Thornton, Beech, Seto and Arkowitz hereby submit this report, Phase II Program Development Description of Changes, to the NAVCON BRIG Miramar for review and consideration as we plan to embark upon the final component of Phase II and the project, Implementation Planning.

The NAVCON BRIG Miramar SOTP provides treatment designed to mitigate the risk for future sexual offending presented by US Armed Forces personnel who have committed sexual offenses while serving in the US Navy, Army, Air Force, Marines, Coast Guard and have been sentenced to a period of confinement of less than 10 years. The SOTP was developed over 22 years ago and the most recent program update was over 12 years ago. A one-year project to evaluate, update and revise the SOTP was initiated on September 24th, 2014.

Phase I occurred September 24, 2014 through March 19, 2015 and culminated in the report entitled Phase I Program Evaluation Report. Shortly after Phase I CCCFP sent a letter to Mr. Peck and the NAVCON BRIG Miramar program suggesting three immediate changes (Appendix I). Phase II involved a period of collaborative discussions and decisions about program changes to address the challenges revealed in the program evaluation phase and occurred March 20 through June 19, 2015. The current report, Phase II Program Development Description of Changes, describes the changes and additions that will be made to the NAVCON BRIG SOTP, providing readers an overview of both the content and structure of the new program. The program development recommendations related to internet offenders have been modified since the date of the program evaluation report in response to new knowledge about the sexual offender composition of the NAVCON Brig. Namely, currently there is not a sufficient number of internet only offenders to support the resource allocation for an Internet Only treatment track.

The revisions and new features of the NAVCON BRIG SOTP resulting from this project are empirically supported based on program specific data collection and analysis, extant published research and authoritative guidance on best practices in sexual offender treatment, and the expertise of the development team. Designed by a group of international experts in the field of sexual offender research, treatment and assessment, and representing the state of the art, the new program is being designed to be both comprehensive and flexible in order to accommodate the individual needs of the prisoners, census fluctuations, and outcome evaluation.

The final phase of the project now commences and will conclude on September 24, 2015. This involves ongoing collaboration with the NAVCON BRIG SOTP clinical services staff to refine and plan to implement program changes. It includes staff training, policy consultation, and materials development. A third and final report will be submitted on September 23, 2015 and will summarize Phases I and II and the Implementation Plan.

Main Report

Description of Changes

Purpose

This report describes the main proposed changes to the NAVCON BRIG SOTP. It describes how they address the concerns about the program's adherence to best practice standards that emerged out of the Program Evaluation conducted in Phase I of the current project. These changes are detailed in an effort to facilitate program approval and prepare for implementation planning. The next step is for the NAVCON BRIG to review and collaborate with the project team to revise and solidify these recommendations followed by implementation planning.

Background

As detailed in the Phase I report, contemporary evidenced based standards are rooted in the Risk-Needs-Responsivity (R-N-R) model (Andrews & Bonta, 2010). In general, programs are considered to align with best practice standards for contemporary sexual offender treatment when they adhere to all three of the model's principles.

The current NAVCON BRIG Miramar SOTP is based on a Relapse Prevention conceptual model that was developed in the late 1990s, prior to the R-N-R model being widely accepted in the sexual offender treatment field. As such, there is much room for contemporizing the program. The NAVCON BRIG SOTP is an exemplar of treatment from the Relapse Prevention era. Such programs, as originally crafted, tended to apply a one-size-fits-all approach, thus not following the Risk Principle. Further, treatment targets common among programs of that era were formulated prior to knowledge about what needs should be targeted in treatment in order to maximally reduce the likelihood of sexual recidivism, i.e., the Criminogenic Needs for sexual recidivism (Harkins & Beech, 2007a, b). Moreover, the field did not fully appreciate the impact of the therapist and the therapeutic environment on outcome or how best to engage offenders meaningfully in treatment. Hence, methods from that era tend to be more rigid and confrontational, and less individualized and motivational than current best practice standards (Harkins & Beech, 2007a, b).

Improved Conformity with the Risk Principle

Results of the program evaluation regarding its degree of adherence to the Risk Principle revealed that the NAVCON BRIG Miramar SOTP can be characterized as a one-size-fits-all program. This means that the program involves a fixed set of interventions that are applied equally to all participants. There is little opportunity to calibrate the treatment intensity to the level of risk (i.e. provide more treatment to more dangerous offenders and less to less dangerous offenders). The duration of the current program means that those serving less than two years only receive brief psycho-educational didactic training (SOED), despite that a quarter of those serving shorter sentences present higher levels of risk. On the other hand, every prisoner with a sentence long enough to complete the standard two-year program is provided it, regardless of his level of risk. There is no option to make the program shorter or longer. This lack of fit between duration of treatment and risk is inefficient from a resource standpoint.

Recommendations. To achieve conformity with the Risk Principle, the consultation team recommends substantive revision to the duration and intensity of the SOTP. It is proposed that all sexual offenders participate in an 11-week psycho-educational group (Phase I).

An individual assessment conducted early in each prisoner's sentence will identify his baseline level of risk. Low risk offenders with no overriding case features will receive no treatment in the SOTP beyond Phase I. The intensity of treatment will be individualized such that the duration of treatment will differ among participants depending upon the number of treatment targets and the degree to which the participant successfully completes each target. Higher risk offenders will receive more treatment than moderate risk offenders. Low risk offenders will not be exposed to the markedly more deviant material of the higher risk offenders. For example, a prisoner with sexual offending against children and adults will participate in treatment to target both victim types. In contrast, a prisoner with adult victims only will participate in treatment to target adult victims and he will not be required to complete assignments related to child victims. While all participants in a treatment track will receive some common assignments, the clinical team will exercise discretion in amending some treatment requirements to correspond to individual participant risk (and also to need and responsivity). For example, if a participant does not demonstrate benefit from an assignment to target his interpersonal deficits, the clinician will assign a different assignment to target the problem in a different manner.

Individual therapy, regular case review by the team, and structured assessment at different junctures in the programming will allow for decisions to titrate or increase treatment according to changes in risk.

Current program census information indicates that there are fewer SOTP participants who have exclusively committed Internet offenses then we initially ascertained. Internet only sexual offenders typically present a very low risk for future contact offenses (Eke, Seto & Williams, 2011; Seto & Eke, 2015). This new information prompted us to move away from our decision to implement an internet-only group. Internet only offenders will be placed in the non-standard track (to be renamed by program), along with other types of lower risk offenders, including Category B offenders as defined on the Static-99R risk assessment instrument, those with military defined sexual offenses only, and other non-contact offenders. When the number of internet-only offenders is sufficient, the NAVCON BRIG can conveniently utilize the non-standard track curriculum to facilitate an internet-only sexual offender treatment group.

Improved Conformity with the Need Principle

The program evaluation revealed several opportunities to improve conformance with the Need Principle. There are three criminogenic needs common among the NAVCON BRIG Miramar SOTP participants: Dysfunctional Coping, Sexual Preoccupation, and Lack of Emotionally Intimate Relationships with Adults. Further, the program lacks any assessment of criminogenic needs.

Recommendations. Instead of giving equal weight to all treatment factors found among sexual offenders in general, the program should focus most of its efforts on targeting the three risk factors most common among its unique population of sexual offenders: Dysfunctional Coping, Sexual Preoccupation, and Lack of Emotionally Intimate Relationships with Adults. A substantial portion of the treatment curriculum has been redesigned to focus on these.

Further, the program will benefit from developing out of session assignments and activities for prisoners to practice their treatment gains in these three areas.

It is recommended the program implement a process of early assessment of criminogenic needs so that treatment can be individualized. This will facilitate a program structure that can be individually responsive rather than requiring all participants to complete the same tasks.

Individual therapy, regular case review by the team, and structured assessment at different junctures in the programming will inform decisions about participant's satisfactory completion of treatment targets.

While the program will need some material to address less common criminogenic needs (e.g. sexual deviancy, general antisociality, an impulsive disorganized lifestyle, resistance to authority, general criminality) that present among its atypical sexual offenders, the amount of focus on these other factors should be greatly reduced. This re-proportioning of treatment content to relevant need factors is reflected in the proposed new curriculum.

The program's current strong focus on sexual deviancy is a particularly poor fit for its population as the majority are not highly sexually deviant, i.e. have pedophilic or sexually sadistic preferences. However, this is a salient criminogenic need for a significant minority of offenders. An overly intense and broad focus, on sexual deviancy runs the risk of convincing those prisoners with transient problematic sexual behavior that they are more pathological then they really are. This can also promote shaming. Resultantly, we have not only reduced the heavy focus on sexual deviancy, applying it only to those whose can benefit from it, but also recalibrated the tone of the assignments and clinical staff communications away from excessive deviancy focus.

We also found serious challenges to the NAVCON BRIG Miramar obtaining accurate knowledge about the index sex offense. This speaks to the issue of accurately assessing sexual deviancy. We have already recommended an immediate partial remediation to receive more complete records, which we are told has already been achieved. We also recommend expanded polygraph assessments to address this barrier.

The overall program has been redesigned to significantly reduce or remove material that is not empirically associated with reduced recidivism (e.g., victim empathy, full disclosure). Treatment material and assignments that were excessive, unnecessarily redundant, or potentially harmful (e.g., requiring prisoners to undergo treatment on issues that are not problematic such as child sexual interest when there is no evidence of such). The resultant program more directly focuses its resources on addressing the factors that need to change in order to prevent recidivism.

In light of the fact that criminogenic needs can be embedded in dysfunctional ways of coping due to adverse childhood or adulthood experiences and the feedback from staff and prisoners suggesting that a significant portion of the NAVCON BRIG population has serious issues related to trauma, it is evident that the new program must attend to this need. Likewise, the relationship of substance abuse to sexual offending is relatively common in this population and will need to become a central component of the sexual offense treatment plan for those participants whom this applies. Relatedly, those whose offenses solely involved consensual sex but with a person under the influence of alcohol (as opposed to with a person who was inebriated such that consent was not possible), are not considered high risk or deviant sexual offenders and as such, substance abuse treatment and Phase I are more fitting treatment interventions. We also recommend adding a trauma focused treatment group, trauma assessment, and refining the substance abuse treatment program to allow discussion of the intersection of substance abuse and sexual abuse in the prisoner's whole treatment, as opposed to getting sexual offense and substance abuse treatment separately with no crossover of content.

There is no need to provide any substantive treatment to sexual offenders who are defined so only by military law (those prisoners whose sexual behavior would not be considered criminal should their offenses have occurred as a civilian), for example adultery, fraternization and having consensual sex while under the influence.

Improved Conformity with the Responsivity Principle

The program evaluation revealed considerable opportunities for the NAVCON BRIG Miramar SOTP to improve its conformance to the Responsivity Principle. A consistent picture emerged from our observation of treatment groups, staff focus groups, prisoner focus groups, and the analysis of the therapeutic climate questionnaires.

The program presently involves individuals working through a standard set of assignments, presenting them in group, and receiving limited feedback. Psychologists facilitating groups generally appear to have a demeanor that is poised and respectful but therapeutically unresponsive, for example, rarely making eye contact or statements or gestures of therapeutic empathy, warmth, or encouragement. Technicians appear to be insufficiently trained for working with sexual offenders, seldom speak in group, dislike the sexual offenders they are treating, and displeased that they are assigned to the task of being part of the SOTP group.

The current design of the program seems to permit little opportunity for a true psychotherapeutic process to take place during group sessions. Since there is no individual component of the treatment program, this problem is grave as it essentially means there is no therapy component. Optimal therapist behaviors include: displays of genuine warmth and empathy towards treatment participants; behaviors that stimulate change such as asking evocative Socratic questions that elicit deeper cognitive and affective processing; and validating emotional experiences and difficulties, as well as encouraging and rewarding steps towards growth.

Treatment groups currently provide an overly structured experience. This can close down opportunities for re-experiencing some of the emotions and challenges that cause and result from the Criminogenic Needs. Rather, it is suggested to use the group process as an opportunity to better understand and cope with these difficult experiences. Currently, the group process is both too constraining such that participants don't feel free to express their feelings and therapists are prevented from providing insightful questions or feedback.

Concerns also emerged about a number of specific exercises used in the present program. However, the big picture issue appears to be a program design that makes it hard for a true psychotherapeutic process to take place.

Recommendations. Improved conformity with the Responsivity Principle will be attained by a program design that stimulates psychotherapeutic process. The clinical director or other designee will be responsible for assuring the level of psychotherapeutic skill of the psychologists and technicians that facilitate the program. The consultant group will provide a training to improve these skills. Ongoing training and supervision is necessary to maintain skills.

Improved conformity with the Responsivity Principle is also facilitated with the new curriculum, which has substantive focus on motivation and the development of protective factors (rather than simply the control

of risk factors). In addition, treatment has now been framed as way of developing more adaptive ways of satisfying the human needs that were previously mal-adaptively expressed through sexual offending.

Release planning and family involvement will facilitate meaningful engagement and the development of protective factors.

Recognizing and acknowledging the trauma histories among those with such will encourage participants to engage in treatment meaningfully, facilitating trust and program credibility.

An individual therapy component has been added to the program. This will allow not only individualized assessment and treatment planning but will target participant treatment engagement by fostering the experience of empathy, validation, trust, and encouragement.

The new program will expressly encourage its providers to demonstrate a warm, empathic, directive style, to provide encouragement for achievements, and to actively strive to facilitate therapeutic process, therapeutic alliance, and positive group climate during group time. Considerable attention has been given to the role of the technicians since they currently appear to not be provided with the education about sexual offenders and sex offender treatment required for them play a more effective role in the SOTP.

An affirmative focus on stripping all aspects of programming (i.e. over focus on victim empathy and full disclosure) that are likely to evoke shame among participants will further facilitate participant responsivity.

New Curriculum Proposed and Consultation Results

We have been consulted by the program on a myriad of issues through weekly meetings throughout the process of developing the new structure and curriculum for the treatment program. Details of this consultation and our guidance are in Appendix A.

The following appendices describe in some detail the proposed new structure of the program. Detailed curriculum material is included for Phase II Standard Track and outlines of curriculum for the rest of the program.

Future Work

Consultation discussions with the program leaders will continue until the program structure and content contained in this report is refined and approved. Once this consultation and feedback period has been completed we will finalize the remaining curriculum material and work with the program to develop an implementation strategy. This will include staff training in July 2015.

Appendix A: Program Development Questions Submitted by the NAVCON BRIG Miramar

This section lists the questions submitted by the program and the agenda topics of the weekly meetings held by the consultants and the program, along with the consultants' responses or current views on these issues. Our responses are indicated in italics.

Program Wish-List (this was submitted to us just prior to the first report)

1. Need for more meaningful information on offenses - maybe Pre-Trial Agreement information available for some individuals in Parole & Release or Pre-Sentence Reports (which don't currently exist for this population). Seems like we're faced with too little information or the possibility of far too much (as the entire Record of Trial would take a massive amount of time and resources to sift through).

We agree that collateral information about the offense(s) for which the current sentence is imposed is vital for the program to operate effectively. Information about the person's life history and circumstances at the time of offending, such as would be gathered in a Presentence Report, would also be of great value. This is the single administrative change that would best increase the effectiveness of the program. Lacking this information leaves program staff operating under a significant handicap.

DONE. THE PROGRAM NOW ROUTINELY RECEIVES IMPROVED DOCUMENTATION ON THE INSTANT OFFENSE. PROGRAM WILL REPORT BACK WHETHER THIS IS SUFFICIENT TO ALLOW ADEQUATE KNOWLEDGE ABOUT INDEX SEX OFFENSE AND OTHER RELEVANT HISTORICAL FACTORS.

2. Minor Contact Policy - Should we have a policy of no contact (visitation/phone calls/letters) with minors if a prisoner has a sexual conviction against minors (our current policy includes those with convictions of child pornography as well)? If so, should it exclude all minor contact or only minor contact outside of a prisoner's children? With this, keep in mind that any prisoner still would automatically not be allowed to have contact with any child that is on their victim and witness list. If we are to retain the minor contact policy, is there a way of making it easier for prisoners to receive contact? At this point, the main blockage appears to be having the child evaluated by an outside mental health professional to ascertain whether it is in the best interest of the child to have contact.

Family contacts can be a great motivator for someone to turn their life around and are generally a protective factor. The present policy appears overly restrictive. Where family members have not been victimized there should be scope for the treatment team to make an individualized decision about the appropriateness of contact with minors who are family members.

SOME CHANGE TO MINOR CONTACT POLICY MADE. FULL POLICY STILL UNDER REVIEW

3. Possibility of multiple tracks based on risk level - I think we have too much treatment for some and many can't start because their sentences are too short. This relates to another concern of mine, which is the ever-increasing SOTP waitlist. Many sex offenders don't get treatment because they don't have time, so we want to address their needs. However, we don't have enough staff/resources to address the growing number that do have time, which has already led to us increasing our groups from 4 to 6 without increasing staff. That means much more time spent inside group (7.5 additional hours + 1 additional seminar time) and much more spent outside of group (prepping and providing case conferences, writing treatment letters, tracking client progress, reviewing journals...).

We will be developing a more efficient treatment structure for you that will allow you serve more prisoners, including at least some of those with shorter sentences. It may be helpful to note that other jurisdictions have been able to provide effective treatment with significantly fewer sessions than you are presently using.

DONE

4. Incorporation of new and up-dated information (as compared to that currently provided in seminars).

I'm completely open to a full restructuring of the program if need be. If we should do away with seminars completely and change the format in such a way where we provide education for a half hour, then spend the remaining hour on processing the information and going over an assignment from the last lecture (such as how Dr. Wexler's domestic violence treatment program is set up), we can go that way. If we should keep the same structure and do some tweaks, that's good too. I'm more interested in having the best program possible than making smaller changes to fit our comfort and familiarity level.

We will be recommending restructuring and new program materials to go with the new structure.

DONE. WE STILL NEED TO DETERMINE WHAT MATERIAL THE PROGRAM WOULD LIKE ADDED FROM SEMINARS TO NEW PROGRAM

5. Inclusion of risk assessments - uncertain how to do so with current resources, but we all know we need to do this, which leads into the next point. In regard to risk, we're guessing we need Statics and then either the SRA or STABLE, maybe even considering the SOTIPS. We're looking to you for what makes the most sense with our current population and the main focus being treatment.

We will make recommendations for ways of assessing risk, criminogenic needs and progress.

DONE

6. Resources - How do we best utilize our current resources to accommodate the increasing population and the anticipated changes (which appear to need more time and effort to do correctly)? There was some discussion with my supervisors after you left regarding whether our current set up is best (rotation of director positions every 5 years versus permanent positions) and the inequality of the director positions due to changes in our prison population dynamics. We discussed the possibility of maybe having a full-time testing position, combining some of the smaller programs, whether we should only have one provider in group (freeing up technicians), etc. We're all very curious as to what you might think on these ideas.

We agree that there are issues with the current resource model. It will be easier to make good decisions about a future model once a new program model has been worked out. We agree, in particular, that technicians are not being optimally used at present.

ORGANIZATIONAL LEADERSHIP STRUCTURE TO BE DETERMINED UPON FINALIZATION OF NEW PROGRAM STRUCTURE

7. Overhaul of Sex Offender Education - Making the course a truly educational/motivational experience to prepare sex offenders for treatment (either here or in the community). This is the intent, but it's so full of old information, old videos, and appears rather shaming and distancing (especially as videos reference offenses not typical of this population, such as violent serial rapists)

We agree that this needs to be replaced and will assist you with this.

IN PROCESS, -PHASE I

8. Individualizing treatment - perhaps a core curriculum and then more individualized tracks (i.e. DBT for a person with emotion regulation problems, Substance Abuse treatment for those with that need, perhaps specific quarters dedicated to sexual self-regulation or deviant arousal management for those in need, etc.). In individualizing treatment, we're also curious as to whether we're meeting the needs of those with child pornography offenses (and whether clients without convictions for child pornography that present with histories of child pornography use are being addressed correctly). As I've said, I'm not opposed to getting rid of our entire curriculum and having something new if that better fits individualized treatment. We've wrestled with the current one many times trying to fit it to changes in the field and it doesn't seem to work, so some new format and new curriculum would be welcome if it better fits RNR.

In our view, tweaking the existing program structure and curriculum will not be helpful. More substantial

change will be required. There are various possible structures for this and we will discuss possibilities with you before making a final recommendation.

DONE

9. Best way to handle drop-outs and refusers - housing ideas, separate dorms for refusers or moving them to other brigs, therapeutic community for those in treatment, keeping it the way it is? I'm not even really sure if the drop-outs are a problem. As you can see from the information I sent, it really seemed to primarily consist of a new group from Fall Quarter and about half of the reasons seemed to be related to external gains (not needing treatment as a condition for community release, trying to utilize enrollment in treatment to get parole early, using enrollment in treatment to move to a better location to be near family). I can't tell if that's a fluke (as there'd been no drop outs for 2 years prior) or if we're in danger of this becoming a trend, so again, I'll be interested to know what you think.

In general it is better for current treatment participants and potential new participants to be housed separately from those who refuse treatment. It is important to seek to minimize treatment drop-outs as this can be associated with increased risk.

DONE. WE SUBMITTED OUR RECOMMENDATION VIA LETTER THAT ADDRESSES THIS (SEE APPENDIX I, LETTER SUGGESTING IMMEDIATE PROGRAM CHANGES)

Resource Allocation/Staffing

1. What is the minimal amount of time needed to go through Phase I and Phase II?

Typical: Phase I=11weeks; Phase II=approximately 18months; Internet Module = approximately 3 months

So duration of Phases I and II combined would be about 21 months for those who don't need the Internet module and about 24 months for those who do.

However, if someone did Phase I and II in parallel then he could complete it in 15 months if he did not need the Internet module and in 18 months if he did.

Additionally, if someone with only 12 months was highly motivated and their treatment needs were not too extensive it may be possible to provide an abbreviated form of Phase I and II which would still provide some benefit within 12 months.

Please note that the program is designed to provide more treatment for those with more needs so there will be significant variation around these averages.

2. What is the staffing recommended for each kind of group?

   a. *Tech(s) for Phase I*
   b. *Psychologist plus Tech for Phase II (could also do two clinical staff, i.e. psych & lcsw/2 psychs)*
   c. *Arousal Reconditioning Treatments should be done by a clinician (i.e. psych/lcsw; who does this in the current program?)*
   d. *DBT a clinician(s)*
   e. *Mindfulness on Unit by Technician level minimally*

f. *Maintenance by clinician(s)*
g. *Release Prep (do they have someone there who specializes in this? A tech could do this; a sw would be well suited to do this)*
h. *Homework lab (technicians)*
i. *Trauma treatment services (clinician)*

**strive to have male + female co-providers*

3. How should the technicians be used?

Techs will be used as co-facilitators for the SOT groups, and conduct homework labs. Could likely provide Phase I (without a clinician co-provider). They may do mindfulness interventions on the unit, program evaluation tasks, and administer assessments.

4. *Besides Phase I, II, III IV, what are the treatment components of the SOTP? Seminars?*

1. *We need to decide whether to still have any seminars (consider resources in context of new curriculum)*
2. *Arousal Reconditioning Treatments (Covert association, Satiation & Olfactory Aversion & Directed Masturbation)*
3. *DBT*
4. *Mindfulness (Class and Wild Divine Program)*
5. *Home work labs*
6. *Trauma treatment services*
7. *Individual therapy*

5. Debriefing? Supervision? External quality review?

We recommend clinical debriefing among the providers occur immediately after every group session, scheduled for 15 minutes. Supervision and External quality are recommended. Detailed recommendations forthcoming. An important feature of the new program is ongoing training and supervision of its clinical staff. The time involved in these activities should be considered in developing duty statements and allocating resources. We have attached a list of contemporary books about sexual offender treatment that will aid in clinician development (See Appendix J). Other methods of assuring clinician competency such as attending conferences, online and video training, journal review, and inviting speakers are encouraged.

6. What is the clinical staffing structure for group provision?

We recommend moving to a model where each clinician is the lead provider for a caseload (their treatment group(s). Need to create list of clinician expectations for caseload and estimate clinician hours required beyond provision of group sessions, i.e. individual sessions, progress review, etc.

7. Frequency and focus of individual therapy? Who provides?

Recommended dosage is at least once per month beginning after the individual has consented to

treatment and just before Phase II. It would be titrating according to need after Phase II. The clinician who provides/will provide the Phase treatment.

Assessments

1. Case conference decisions, which option would be best: 1) quarterly with full team; 2) quarterly with provider and tech who facilitate the group; 3) 3 total: beginning treatment, 1/2 way point, end treatment; 4) no case conference - treatment providers cover progress in individual? Initial Assessment Interview and Write up, -primary treatment provider

- *Initial introductory conference with participant (with the primary treatment provider (PTP) and primary treatment technician (PTT)).*
- *Case conference with participant after Needs Assessment (2nd Assessment Report), at the end of Phase II, and at Release Planning by group facilitators (PTP & PTT);*
- *Yearly(?) by full team: this needs to be determined, some conferencing among all who treat the case is recommended*
  **conferences may replace monthly individual session for that month;*

2. Detail the kinds of assessments, when they will occur and who will be responsible for them.

Throughout the SOTP participants will undergo four assessments, resulting in written reports:

- *Initial Assessment (carried out before or during Phase 1)*
- *Individualized Treatment Plan Assessment (carried out part way through Phase 2),*
- *Progress Assessment (carried out at the end of Phase 2),*
- *Program Completion Assessment (carried out prior to release).*

Prior to Initial Assessment participant has an initial meeting with the program director.

Initial Assessment will be used for assigning track and identifying those with trauma treatment needs; program will continue with its regular method of assessing substance abuse treatment needs. Tests administered= St99R, CPORT, TSI-2, and MSI-I or MIDSA and Beck Depression and Beck Anxiety Inventories. Most of these can be administered by a technician. When one scores low risk on St99R and CPORT they receive no treatment beyond Phase I. We will provide a training on the CPORT electronically. If program needs a training on the Static-99R we will also provide this electronically. We will provide a report example/template. One possible method is for the tech to administer testing and provide to psychologist, who interviews participant and writes up report. Need to decide whether tech or psychologist rates St99R, would be hard to train new techs regularly to score St99R. Also need to resolve which psychologist is responsible for writing the assessment report, -could have a position that does mostly just this or it could be divided up among the providers of the SOTP. Assessment determines track placement; clinical director assigns to the group. Only those with sentences long enough to complete at least the reduced form of Phase II will undergo Initial Assessment. This probably means that only persons with sentences of at least 12 months will be assessed but there will be further consideration of this.

We also recommend a Group Climate Assessment and may want to consider a consumer satisfaction survey done at regular intervals (i.e. quarterly). They can create such a survey in house or look at work by David Prescott.

3. Can we get rid of the GSBI? Shall we continue with the MMPI?

They should use MSI (possibly MSI-II) instead of GSBI
Consider MIDSA in lieu of MSI
They should not use the MMPI
They should use the TSI-2 together with possibly the Beck Anxiety and Depression Inventories

4. Describe how and when we will get training on each of the assessment tools.

We will provide training on some over the three-day training in July and others electronically. Program will need to develop a system of training new staff and refreshing training of tenured staff.

5. You *recommended mindfulness/meditation training, when/where will that occur?*

- *Tony provided information related to Wild Divine program and will be a contact for using that program therapeutically.*
- *We will not be able to provide them sufficient mindfulness training. They might seek someone local to provide Mindfulness meditation training.*
- *http://www.mindfullivingprograms.com/aboutcourse.php - provides an online training program but also training in CA; these are some of the leading exponents of Mindfulness-based stress reduction in the world*
- *If they like, we can attempt to connect them with SO field leaders in mindfulness for SOT.*
- *The VA Palo Alto has a great training program that includes some mindfulness, also DBT, Seeking Safety, Acceptance and Commitment therapy training*

6. List and describe the PPG and Polygraph assessments and policy recommendations for when each is to be conducted, and other PPG/Poly issues that have emerged.

Ideally:

1. Instant Offense Poly (when applicable), before completion of Phase I to assist with tracking decision and only for those with sentences long enough to start Phase II (i.e. greater than 6 months since Phase I is 11 weeks, but can do concurrent to Phase II)

2. Sexual History Poly in Phase II and PPG and PPG poly (for non-responders and non-deviant outcomes); Sexual Thoughts and Fantasies/ Masturbation Poly and Re-Poly's for those who did not pass Sexual Hx poly prior to treatment need assessment, happens about half way through Phase II

3. STF/Masturbation Re-Poly for those who did not pass after arousal reconditioning module

We recommend the PPG interpretation should go in two steps: (1) whether a PPG assessment has provided valid results (2) Determine whether an offense-related arousal pattern requiring intervention is present.

The following criteria are recommended for determining validity: at least one response to sexual stimulus greater than to neutral stimulus, at least one response greater than 2.5mm (approx. 10% of full erection

for average man) and no evidence of faking from the polygraph examination. The polygraph examination would be carried out when the results appeared to indicate a preference for consensual sex with adults (the profile that offenders have a motivation to fake) or if none of their penile responses exceed 2.5mm.

The report should then record mm of circumference change in response to stimuli and should identify as indicating significant arousal to a deviant stimulus any response to those stimuli that equals or exceeds his strongest response to the normative category (consensual sex with an adult). Thus a response to child stimuli that equals or exceeds his strongest response to either male or female adults would indicate a need to offer behavioral treatment to reduce deviant sexual arousal to children. Similarly, a need to offer behavioral treatment to reduce deviant sexual arousal to coercion would be indicated where a response to stimuli that depict use of threats of physical force to impose sex is as strong or stronger than his response to stimuli depicting consensual sex.

Re-testing is required if responses are not valid. It might not be possible for some individuals due to non-responsiveness in the lab or medical issues. Note this is a relative criterion, not an absolute criterion.

As detailed elsewhere, we recommend increased use of polygraph but less use of PPG (no need to reassess on PPG after arousal reconditioning treatment(s)

PPG evaluator should use Limestone's updated stimulus set, sometimes known as Real Child Voices.

7. Attached are redacted polygraphs. Looks like the marker bled through when I'd redacted them, so I'm hoping they're not too hard to read. What changes should be made in the standard template for the polygraph report? What changes should be made in what is done with the polygraph report?

Will review current template for polygraph report and reply

8. If we identify an individual with high risk but has too short of a sentence for the longer, more intensive program, do we place him in the shorter program or not treat?

If he is high risk and has less than 12 months, program will need increased intensity so that he can complete the abbreviated program. The program may not have the resources to provide Phase II treatment for those serving less than 12 months since doing so would require increasing the rate of sessions per week. If resources do not permit such individuals might still participate in Phase I. Phase I will not be sufficient to address the risk of high or even moderate risk offenders however so warning the community to which the individual will be released may be the most that is possible. For individuals having between 12 months and 24 months time available at the Brig, adaptations of the program are possible that will provide adequate treatment, depending on how extensive their treatment needs are. In the program evaluation, we did not find a large number that were high risk among the too short for treatment group, however we did not have a large sample and your census information seems to vary considerably from year to year (per Dr. N.)

Consent Form/Enrollment & Completion Requirements/Policies

1. Is the current consent form ok?

To be completed. When program approves admission/completion requirements, they should draft revised consent form and we can review

2. Denial/Disclosure. Currently, an individual can enter treatment only admitting to one offense. However, in order to complete treatment, they must be admitting to all of their convictions and discussing their relevance to assignments. What are the entry and completion criteria?

Participant must admit to having a problem with his sexual behavior for entry.

To acceptably complete the program:

- *A participant must acknowledge legitimate community concern that he might repeat the kinds of offending that he is officially known to have engaged in and be motivated to live so as to allay that concern.*
- *A participant and his treatment providers must have come to a shared view of the main criminogenic factors that contributed to his past offending and must have developed internal controls and a broader array of protective factors relevant to managing these factors and be applying these within the Brig in so far as that is possible in that setting*.*

These criteria put the emphasis on changes that are the most related to reduction in risk.

**Polygraph to assist with knowledge about instant offense and sexual history.*

3. What should be our minor contact policy? What about possession of photos of children?

We have supported minor changes to the minor contact policy and will make more detailed recommendations later. We are also in the process of considering the issue of possessing photos of non-victim family members.

Consultants have a question about how program comports procedurally to CANRA. For example, we note that the autobiography assignment solicits strong detail about non-detected sex offenses. Do you report these to authorities when they are disclosed? How do you avoid mandatory reporting obligation? Do you have some kind of treatment exemption? How is program handling AB1775, -the new addition to CANRA that mandates reporting child pornography?

New Curriculum/Treatment

1. Please summarize how and when journaling will be done. Currently journaling is done 1st and 3rd quarter. The 3rd quarter are the arousal journals. Will either of these continue in the new program?

Perhaps arousal journals will only be necessary for those in the deviant arousal lab?

Journaling is integrated with individual treatment in the new program in Phase II and is done throughout. This does include some record of masturbatory behavior.

We haven't fully revised the arousal reconditioning treatments (this is what Dr. N is referring to as deviant arousal lab) yet so we have not decided yet if there will be different journaling for that.

2. What is the policy and when one would get arousal reconditioning treatment? Would it always involve Olfactory Aversion? In current program, arousal reconditioning treatment are assigned to those who self report or poly assisted self disclosure of deviant fantasies, or deviant behaviors or PPG reveals significant arousal to sexual deviance that is consistent with his known arousal pattern. I.e. an adult rapist who shows significant arousal to children on PPG does not get arousal reconditioning unless he self-reports/discloses deviant fantasies/behaviors involving children.

Should everyone be doing the covert satiation behavior techniques?

NO

It is recommended that behavioral treatment to reduce deviant sexual arousal (verbal satiation and olfactory aversion) be assigned where PPG assessment (see earlier discussion of criteria for the PPG) indicates a deviant arousal pattern and he has behaved in a way consistent with that pattern in the past. Additionally, behavioral treatment to reduce deviant sexual arousal would be indicated if he self-reported ongoing masturbation deviant fantasies or engaged in deviant behavior within the facility.

We recommend that Verbal Satiation techniques be employed first and that Olfactory Aversion be adopted only if there is a continued problem of hard to control, intrusive deviant fantasy, or upon request.

How long after these arousal reconditioning treatment should the follow up PPG be administered? Right now, it is at the end of the program.

It is generally not necessary to follow up arousal reconditioning treatment with PPG as often the PPG arousal doesn't change but the sexual fantasies/masturbation does and this will be assessed via polygraph.

3. What changes should be made to the olfactory treatment? To the covert tapes treatment?

Further review of this will be provided

4. The following assignments were found to beneficial by our team and generally noted by clients as having value:

Autobiography, Problems List, Incentives List, Though by Thought, Role Plays (specifically Coping Skills Game and Questions Victims Ask), Behavioral Indicators, and Survival Plan.

1) The Autobiography is nice because it helps the group get to know a new member's personal history, but many of the questions on it don't seem to add a lot of value (Who named you and why? for example). On the other hand, more relevant questions (such as have you been able to sustain an uninterrupted two year live in relationship with an intimate partner or how do you feel about women being in positions of authority) are absent.

We included it and have made minor modifications. We plan to review it further for relevance. We recommend program review the assignment and suggest modification that would make it more meaningful to military population. E.g., might consider including some questions relative to military service, i.e. why joined? Support network's response? Benefitted the most/least from what parts? Any life changing experiences? Thoughts/Feelings about discharging?

2) Problems list and incentives list are nice motivators and often clients in much later quarters (including maintenance) refer back to these as motivators for treatment. To me though, I'd like to focus more on strengths and pro-social goals rather than only avoiding problems and consequences.

We agree.

3) Thought by thought seems to force individuals to really look at cognitive distortions and planning, getting them away from the "it just happened" mentality, but maybe it might be better to look at the most impactful offense rather than the first time offending (in some cases, people began looking at child pornography when they were young teenagers and may not remember what led them to initially engage in this behavior). I know sometimes they say they have to "make up stuff" for the assignment, but I don't really know if that's the case. We ask them to look as best as they can at what their thought process was, how they allowed themselves to make the decision to offend, and we know they won't have it exact, but we want them to focus here on reflecting on that time and trying to put the pieces together. I've had many group member say (sometimes at the time of completing the assignment, sometimes several quarters later or even in maintenance) that this was where they really started to understand their offense and their risk factors.

An analysis similar to this is included in the new curriculum.

4) I feel we need more in the moment practice and more role plays. Questions Victims Ask may help with empathy (which I know has not been shown as a robust risk factor), but also serves the function of helping them consider how not to do more harm (often by being callous, invalidating, or pressuring someone for forgiveness) in the event that they are confronted by a victim, which has happened to some of them

We included a number of role-plays and clinicians always retain discretion to add role plays or other material throughout the course of treatment. The new curriculum does not focus on empathy for past victims as this does not appear to be related to future risk. It does include material related to empathy for people in their current and future environment, something that is more risk-related.

5) Behavioral Indicators - mostly we just want to make sure they can come up with objective ways of knowing when they're crossing a line or starting to return to an offense cycle

In the new curriculum, the Self-Control Cards include Warning Signs which may be helpful here.

6) Survival Plan - Need a place like this to tie everything together. However, I think it's too cumbersome for everyday life. We had begun working on maybe putting together a one page plan or urge control card, in which someone might have support network names and contact numbers, top 5 coping skills, top 5 warning signs that they're entering a high risk situation. Something like that. I think having something tangible that they can grab when they need it might be useful if they find themselves in a bad situation. Maybe needs incentives or a commitment statement on it too. I've attached my initial attempt at this, although it's not complete.

The new curriculum includes their creating both a Resource Folder which has a more extensive set of resources for them to draw on and Self-Control cards which can be carried with them. We can adapt this further to include program's idea more directly.

5. Please explain the Resource Library.

Program to create an accessible resource library for those in SOTP (even if they just receive Phase I) through release, including waitlisted. This will include a variety of books, videos, etc. to facilitate personal rehabilitation efforts for sexual offending and associated problems. Participants can check out materials and clinicians can also use materials to create supplemental assignments. A key idea of the SOPT program is that each participant should always be working on some kind of assignment. Program may want to plan an ongoing budget for the resource library.

We are developing a list of recommended resources for this list.

6. A lot have trauma treatment needs, how will this be addressed?

We will screen for trauma treatment needs at the initial assessment with the TSI-2. If there is concern about malingering past trauma, polygraph may be utilized. Those with trauma treatment needs may be referred for DBT for sexual offenders (will be mixed with sexual offenders without trauma treatment needs). If DBT is not sufficient, program may assign to trauma treatment services. Program is recommended to create trauma treatment services that include individual and group components. The VA Palo Alto has an excellent PTSD treatment program (i.e. seeking safety, acceptance and commitment, etc.; Foa's work based on reprocessing stimuli associated with trauma until fear reactions extinguish has proved to be effective and there is widely available training for how to apply this technique; EMDR.

Therapeutic Community, etc.

1. You recommended we incorporate features of a therapeutic community. What will this be?

This depends on whether the dorm composition will be comprised of SOTP and waitlist only. We have deferred this issue pending program response to our suggestions about dorm composition.

2. What is the best role for the Aps?

Here are the existing guidelines for AP's. There's a brief paragraph on page 5 of the manual regarding AP's. Essentially, the group members meet at least 3 times a week with their AP's. AP's are maintenance members or group members that are in at least 6th quarter. 1st quarter members are assigned AP's by me and I try to come up with the best fit. However, after 1st quarter, they may choose who they want as

an AP, provided that the person requested is willing to work with them. They usually stick with the person I selected for them and most switches occur because an AP is leaving the facility for parole. However, if there are conflicts with an AP, they can switch to another at the quarter break.

AP's review assignments and provide guidance on assignments to group members. They challenge cognitive distortions and reinforce pro-social and appropriate problem-solving while outside of group. They help members with problem behaviors and encourage them throughout treatment. Often when a member asks to meet with me privately (which may be to disclose a new offense or some other issue they're not quite ready to address to the group as a whole), they typically report the decision to ask me for help came under the advisement of their AP. Also, AP's will occasionally request to meet with me to consult on how to challenge or address an issue with their APE. Typically, the issue is how to get the APE to open up more or to motivate them to stop engaging in a problematic behavior. AP's meet with me on a quarterly basis to discuss their role and questions/challenges they're having. We strongly emphasize that they are there to provide feedback and assistance, but not to dictate treatment. Often we talk about how an APE's success or failure is not their responsibility (as they sometimes take it as a personal failure if someone does not do well on an assignment). The intention for the APE is to provide the APE with someone to open up to that understands offending from an offenders point of view and to provide opportunity for problem-solving and communication with others. We encourage building trust and support networks and this gives them practice in these areas as well. For the AP themselves, it provides an opportunity to better understand the material (as they now are trying to explain it to someone else), to work on restitution, callousness, and selfish behaviors (by now having to take time to work on helping someone else), and improving interpersonal skills and communication with others.

We made recommendations regarding housing SOTP and waitlisted together and isolating refusers and treatment resistant from SOTP and waitlisted. With regard to APs, our main concern is that more highly antisocial people not be given this role. May want to utilize PCL screen scores to help rule out prisoners from becoming Aps. The behavior of the AP and the relationship with the junior member needs to be monitored to some degree.

Continuity Of Care

1. Regarding Probation, I've spoken to a USPO in California. All USPO's in California use CASOMB standards and thus need to have our clients re-assessed through CASOMB certified providers upon release. If we were CASOMB certified and utilized their assessments, they would be quite happy and it would cut down on what the clients would need to do upon release. However, as you know, we only release a small percent of our clients to California. The PO also told me that all Federal Probation Officers across the country utilize the Containment Model, not just California.

We recommend the Brig use Stable-2007 and Static-99R as this will meet general community treatment standards in California.

2. Are we doing our best to successfully prepare our clients for their transition from here out into society? In considering this, should we increase the lines of communication with probation officers and should we provide them our assessments once we start doing them? Also, should we seek CASOMB or some other certification to assist in appreciation of the credibility of our program to outside agencies that will have influence on our clients' care and supervision upon release? As I'd stated, we're in a

unique position in terms of releasing all over the country, to many locations that may parole officers and treatment providers have never heard of our treatment program and may or may not enforce follow-up treatment or even ignore any of the treatment clients have completed here. In a perfect world, I'd love to have a community provider that has a program in sync with mine in which a client could complete an in-prison phase of treatment and transition easily into the out-patient portion upon parole. However, that's not the reality and I don't think it could ever be possible with such a huge spectrum of geographic locations and types of providers that may or may not contact me after my client leaves.

We are working on the Release Preparation phase of the new curriculum and will have guidance relate to this issue in due course.

3. Transition:

    a. Which individuals in the current program will transition to the new program and which should finish out with the current program?
    b. Should we avoid placing new arrivals into treatment at this time if they have time to wait in order to reduce the number of individuals needing to transition to the new program?

To be discussed.

Appendix B: Map of Program Components

Initial Assessment and Initial Treatment Assignment

Assigns to Phase II tracks (Standard or Non-Standard)
Assigns to Trauma Treatment Services/DBT for SOTP (Substance Abuse Assessed as current)

Phase I: Remoralization, Attitudes, Values & Education (to be renamed)

Phase II: Standard Track	**Phase II: Non-Standard Track**
Individual and Group Treatment	Individual and Group Treatment
Treatment Need Assessment; Progress Review(s)	Treatment Need Assessment; Progress Review(s)

Supplementary Phase II Treatment Components, assigned based on Treatment Need Assessment

Internet Module

DBT

Trauma Treatment Services

Arousal Reconditioning (Verbal Satiation and Olfactory Aversion)

Mindfulness (Wild Divine Computer Program; Mindfulness)

Phase III: Maintenance

Phase IV Release Preparation

Appendix C: Initial Assessment & Initial Treatment Assignment

Initial Assessment

(for those with 12 or more months to serve)

- Brief Initial Meeting with the SOT Program Director

- Questionnaires administered by a technician
  The MIDSA if the Brig can support the technical requirements of this instrument or version one of the MSI plus Hare's new *psychopathy questionnaire. Also the TSI-2 and the Beck Anxiety and Depression scale.*
- Clinical interview and file review by a psychologist
  Exploration of Issues indicated by questionnaires *to provide a basis for diagnosis and referral to services*

  Analysis of sexual offenses *for which the individual has been charged to distinguish them into: Military Offenses; Prototypical Contact Sex Offenses; and Non-contact Sexual offenses.*

  Military Offenses are here defined as actions that are crimes under military law but which would not be sexual offenses in the civilian world. This would include such things as adultery, consensual sexual behavior when both parties are drunk; consensual sexual behavior between person of different ranks.

  Non-contact Sexual Offenses will be predominantly Internet-mediated offenses such as downloading illegal pornography but would include traditional non-contact offenses such as indecent exposure.

  Scoring Actuarial instruments. *The Static-99R would be scored if the person has at least one charge for a type A sex offense. Note that Military Offenses are not counted as Type A offenses. The CPORT (Child Pornography Offender Risk Tool) should be used for men who have been convicted of one or more child pornography offenses, including possession, distribution or production. It can be used with both child pornography only and so-called dual offenders who have committed both child pornography and contact sexual offenses. It is NOT intended for those who used online technologies to sexually solicit children or to engage in other illegal behavior (e.g., accessing pornography content that contravenes obscenity laws).*

Treatment Track Assignment by SOT Program Director based on Initial Assessment

Referral to DBT - based on trauma-related issues. If the individual has PTSD symptoms clearly related to a specific traumatic event for which there is collateral evidence (may utilize polygraph assessment), and their symptoms aren't sufficiently responsive to DBT, then referral to trauma specific counseling based reprocessing the original incident until extinction is obtained should be considered.

Referral to Phase I - This is provided to all sexual offenders with long enough to complete it when they arrive at the facility. The program takes 11 weeks and is run multiple times a year. Participation in Phase I does not require completion of the Initial Assessment.

Referral to Phase II – Sexual Offenders who have been charged with a non-military sexual offense and also score above the Low Risk category on the Static-99 or the CPORT will be offered this. To participate they must agree that they have a problem with their sexual behavior that they wish to work on and consent after reviewing information about the nature of treatment.

Referral to Phase II Standard Track – Meets criteria for Phase II and has been charged for a prototypical contact sex offense

Referral to Phase II Non-Standard Track - Meets criteria for Phase II and has not been charged for a prototypical contact sex offense

Referral to Internet Module – Meets criteria for Phase II and have committed sexual offenses mediated by the Internet. This includes Solicitation Offenses as well as Child Pornography offenses. This module may be done prior to, after or in parallel to Phase II Standard or Non-Standard tracks. Decisions as to which option applies should be based on when the next Internet Module is running and how long the individual has before he can be released.

Appendix D: Outline Description of Phase II: Standard Track

The Standard Track provides a treatment group that can have up to eight participants and runs twice a week and monthly individual therapy.

The individual sessions are combined with journaling to teach specific skills such as problem solving, to enhance skills that are covered in parts of the curriculum, to assist the individual with parts of the curriculum he finds difficult, and help focus work on the individual needs.

Particularly important parts of the individual sessions include developing the Resource Folder and Self-Control Cards.

Group sessions are 90 minutes in length and divided into two slots with a five-minute break in the middle. Normally one patient will present their work to the group during the first slot, then a second patient will present their work in the second half of the group. When a participant is presenting his work it will be processed by the group to provide him with feedback and, in some modules, their will be role-playing exercises to develop skills.

Each participant will normally get to present their work to the group and have it processed once every two weeks. This leaves them two weeks to work on the assignment that they will present at the next slot.

The number of slots required for an assignment will vary depending on the needs of the individual. The table below indicates the general nature of each module and the expected average number of slots required.

Module	Expected Number of Slots
Introduction to Group – overview of life history	1
Hopes and Fears about treatment – engage motivation, manage fears	1
Understanding Life Goals – Understanding the different potential sources of life-satisfaction and positive & negative ways he has pursued them	1-2
My Autobiography – develop a detailed autobiography including sexual and relationship history. Clarifies the range of different kinds of sexual offending he	2-4

has engaged in and puts it in the context of his life *The participant is eligible to complete his sexual history polygraph examination, his PPG, and his Thoughts & Fantasies Polygraph examination at the end of this module. It is desirable for this to be completed prior to the Offense-Analysis but it must be completed prior to the Treatment Need Analysis*	
My Sexual Preferences & Fantasies – Disclosure to the group of PPG and Sexual Fantasy assessment results. Discussion of methods for managing offense-related arousal Referral to the Arousal Modification module should be based on these assessments	1
Offense-Analysis – identification of risk factors by analysis of events preceding offending. Factors are divided into vulnerabilities occurring over the preceding year and decision-making on the day of the offense	3-4
Life Goals at the Time of Offending – Uses the earlier education about Life Goals to analyze which goals he was pursuing at this time and how he was pursuing them (including offending). He then is asked how he would run his life during that period if he could have a Do-Over. This includes working out how he could have satisfied various life goals without offending	2
Treatment Need Assessment and Feedback – the STABLE-2007 and the ACUTE-2007 are applied by the psychologist providing treatment to characterize Vulnerabilities and	Individual Session

potential future Acute Risk factors. Feedback is provided to the participant. Referral to Mindfulness and DBT treatment components may be made based on the TNA. Results are used by treatment providers to focus subsequent Modules in a way that is	
Resisting Temptation – Understanding and beginning to build defenses against urges to reoffend	2
Protective Factors – Understanding protective factors and beginning to build them in a way that is relevant to his risk factors	1-2
Future Me – Developing an image of a Future Self that he can work toward becoming	1-2
Emotions – Developing increased awareness of emotions and the understanding the kinds of problems people can have with emotions	1
Managing Emotions – Learning about emotion management strategies Note that those with more major problems with emotion regulation should have been referred to Mindfulness and / or DBT	1
Adult Attachment Style – Learn about adult attachment styles and identify their own	1
What do people bring to romantic relationships – Becoming more aware of what contributes to a romantic	2

relationship being successful and identifying assets that they bring	
Better Sex - Understanding issues that can lead to sexual problems in relationships	1
Relationship Skills: expressing feelings – Role play is used to practice this skills	2
Relationship Skills: Empathy – Role play is used to practice this skills	1
Relationship Skills: Giving Support– Role play is used to practice this skills	1
Relationship Skills: Managing Conflict– Role play is used to practice this skills	2
Relationship Skills: Coping with Jealousy– Role play is used to practice this skills	1
Being Alone	1
Bringing it Together	2

Under normal circumstances Standard Track Phase II will take about 18 months to complete. Individuals who don't need all the modules can complete it more quickly. If phase II is run after Phase I this will mean that Phases I and II could take about 21 for those who don't also need the Internet module or 24 months for those who do.

Where it is desired to get someone through the program more quickly Phase II can run in parallel with Phase I so long as initial assessment has been carried out. Similarly Release Preparation can be begun in parallel with the last three months of Phase II if necessary.

If there is a wish to provide services to a higher risk group with less time to serve at the Brig then, resources permitting, Phase II could be run at three sessions a week. Alternatively a minimal version of Phase II could be run that ended the program after the Future Me block, skipping to Bringing it Together.

Appendix E: Outline Description of Phase II: Non-Standard Track

This will receive individuals meeting the criteria for Phase II who have not committed a prototypical contact offense. Most of these will have committed an Internet Offense and be eligible for that module. For the rare cases who aren't eligible for the Internet Module we recommend a functional analysis of their offending similar to that included in the Internet Module be run in individual therapy.

After either the Internet Module or this functional analysis have been completed they can join an open Non-Standard Group and work on the following modules adapted from the Standard Track. Individual sessions, as for the Standard track would also be provided.

Module
Introduction to Group – overview of life history
What I learned – presentation to the group of what they learned from the Internet Track or from the functional analysis of other non-contact offending
Understanding Life Goals – Understanding the different potential sources of life-satisfaction and positive & negative ways he has pursued them
My Sexual Preferences & Fantasies – Disclosure to the group of PPG and Sexual Fantasy assessment results. Discussion of methods for managing offense-related arousal Referral to the Arousal Management module should be based on these assessments
Life Goals at the Time of Offending – Uses the earlier education about Life Goals to analyze which goals he was pursuing at this time and how he was pursuing them (including offending). He then is asked how he would run his life during that period if he could have a Do-

Over. This includes working out how he could have satisfied various life goals without offending
Treatment Need Assessment and Feedback – the STABLE-2007 and the ACUTE-2007 are applied by the psychologist providing treatment to characterize Vulnerabilities and potential future Acute Risk factors. Feedback is provided to the participant. Referral to Mindfulness and DBT treatment components may be made based on the TNA. Results are used by treatment providers to focus subsequent Modules in a way that is
Protective Factors – Understanding protective factors and beginning to build them in a way that is relevant to his risk factors
Emotions – Developing increased awareness of emotions and the understanding the kinds of problems people can have with emotions
Managing Emotions – Learning about emotion management strategies Note that those with more major problems with emotion regulation should have been referred to Mindfulness and / or DBT
Adult Attachment Style – Learn about adult attachment styles and identify their own
What do people bring to romantic relationships – Becoming more aware of what contributes to a romantic

relationship being successful and identifying assets that they bring
Better Sex - Understanding issues that can lead to sexual problems in relationships
Relationship Skills: expressing feelings – Role play is used to practice this skills
Relationship Skills: Empathy – Role play is used to practice this skills
Relationship Skills: Giving Support– Role play is used to practice this skills
Relationship Skills: Managing Conflict– Role play is used to practice this skills
Relationship Skills: Coping with Jealousy– Role play is used to practice this skills
Being Alone
Bringing it Together

Appendix F: Internet Module for NAVCON BRIG Sex Offender Treatment Program

This Internet module is provided in conjunction with the standard and non-standard treatment tracks. Unlike the main treatment tracks, which have rolling admissions as new members join, the Internet module is best provided when a sufficient number of individuals (preferably 6 to 8) require this module.

This module is intended for individuals who used the internet as part of their sexual offending (e.g., illegal pornography use, sexual solicitation of minors) OR because problematic internet use has been identified as an important treatment need (e.g., internet use was not related to their sexual offending but treatment reveals excessive online pornography use is causing distress or impairment).

This module is not intended to be a stand-alone treatment option because the focus is on the role of the internet in problem sexual behavior and developing an understanding of online behavior and how to more effectively manage it.

Theoretical Background

Seto (2013) has described how online offenders are similar to and different from contact offenders. In particular, child pornography offenders are more likely to be pedophilic than contact offenders, but on average they are less antisocial as indicated by criminal history, antisocial personality traits, or offense-supportive attitudes and beliefs. Comparison studies suggest there are two main domains where online offenders have particular needs: (1) interpersonal relationship functioning; and (2) sexual self-regulation.

Seto et al. (2011) conducted a meta-analysis of online offender studies and found that approximately one in eight have a criminal record for contact sexual offending. In the six studies with self-reported offending available through polygraph interviews or treatment disclosures, approximately half of the online offenders admitted to one or more contact sexual offenses. This suggests the online offender population at the Brig will be comprised of online-only offenders or dual offenders who have committed both online and contact sexual offenses.

Elliott and Beech (2009) have suggested that there are four broad types of individuals who by their use of the Internet propagate sexually abuse behaviors against children: (1) *emotionally dysregulated offenders*, consisting of those accessing impulsively, or out of a general curiosity, and who carry out this behavior sporadically, potentially as part of a broader interest in pornography (including 'extreme' pornography) that may, or may not always, be related to a specific sexual interest in children; (2) *fantasy driven/online-only offenders*, consisting of those who access/trade images to fuel a sexual interest in children, but who have no known history of contact sexual offending; (3) *direct victimization offenders*, consisting of those who utilize online technologies as part of a larger pattern of contact, and non-contact, sexual offending, including sexually explicit material involving

children, and the gaining and subsequently abusing the trust of an individual of children online, in order to facilitate the later commission of contact sexual offenses (Krone, 2004); and (4) *commercial exploitation offenders*, consisting of the criminally-minded who produce or trade images to make money. This Internet track will be aimed primarily at the emotionally dysregulated and the fantasy driven groups.

The emotional dysregulation pathway describes individuals who have difficulties in the self-regulation of emotions and behavior, which seems to be a strong motivation in those who browse the internet looking for deviant pornography. Hence, these individuals will often turn to online activities as a way of dealing with difficult emotional states, such as depression, anxiety and stress A cognitive style relating to the self, and the world around the individual, that includes problems such as: self-doubt, low self-efficacy, and negative self-appraisal (e.g., 'I'm only good on the Internet'; 'The Internet is the only place I am respected'; 'Nobody loves me offline'), could perhaps describe this group. Quayle and Taylor (2002) describe how Internet offenders in their sample reported that they could escape from unpleasant realities of viewing sexually explicit material of children, describing how they 'shut themselves off' from their personal circumstances, finding pleasure in online sexual arousal and masturbation (i.e., using sex as a coping strategy). As regards the use of child pornography, strong negative mood states result in a lack of control and, in conjunction with sexual desire, can lead to the individual seeking contact with children to meet their sexual needs.

As for an explanation of the fantasy driven/on-line only offender, the intimacy deficit pathway group, the Internet appears to provide a social outlet for individuals who have difficulties initiating, and maintaining, relationships with other appropriate adults. Online sexual behaviors can be particularly significant for individuals who have trouble obtaining face-to-face sexual contact, and hence those with intimacy deficits may be prone to developing online sexual habits. Research suggests that these offenders are often overly self-conscious, lack assertiveness, lack empathy in relationships, and demonstrate low levels of self-efficacy (Laulik, Allam, & Sheridan, 2007), are emotionally lonely, inadequate, and have poor self-esteem (Middleton, Elliott, Mandeville-Norden & Beech, 2006).

INTRODUCTIONS

Goals for Treatment Participants
• Introductions of group members to each other • Introduction of the facilitator • Introduction to internet module structure and goals • Discuss expectations for group sessions

Guidance for Facilitator
The purpose of this session is to orient treatment participants to the module content and expectations, and to answer any questions or concerns that participants might have. Participants briefly introduce themselves to each other, describing major life events that led them to becoming the man they are today, both positive and negative. Participants should also briefly describe the sexual offense(s) that led to the current sentence, but this should not be the focus. Participants also discuss the role of the internet in the offenses or in the problems they have faced.

HOPES AND FEARS

Goals for Treatment Participants
• Reflect on hopes and fears for internet module • Develop realistic expectations of what can be accomplished in the group • Identify reasons they might benefit from the internet module • Develop confidence that they can benefit and overcome fears/obstacles • Encourage team attitude, including support and empathy for each other

Guidance for Facilitator
Invite participants to describe hopes and fears for internet module. Provide support and empathy. Use motivational engagement techniques in this session, and subsequent sessions, to encourage a change orientation. Motivational engagement techniques include reflective listening, asking open-ended questions, evoking change talk, evoking self-efficacy talk, acknowledging difficulties with change, affirming strengths, and gently pointing out discrepancies between words and actions. See attached summary by Sobell & Sobell regarding motivational interviewing (engagement) techniques. Encourage other group members to give feedback to presenting participant in supportive and encouraging manner.

Handout: modified Internet Dependency Checklist (source: croga.org)

To be answered on the basis of internet access in year prior to arrest. Problematic if yes to 5 or more questions:

1. Did you feel preoccupied with the Internet (think about previous on-line activity or anticipate next on-line session)?

2. Did you feel the need to use the Internet with increasing amounts of time in order to achieve satisfaction?

3. Did you repeatedly make unsuccessful efforts to control, cut back, or stop Internet use?

4. Did you feel restless, moody, depressed, or irritable when attempting to cut down or stop Internet use?

5. Did you stay on-line longer than originally intended?

6. Did you jeopardize or risk the loss of a significant relationship, job, educational or career opportunity because of the Internet?

7. Did you lie to family members, therapist, or others to conceal the extent of involvement with the Internet?

8. Did you use the Internet as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)?

FUNCTIONAL ANALYSIS OF ONLINE BEHAVIOR

Goals for Treatment Participants

- Understand factors that played role in problematic internet behavior
- Identify antecedents to problematic internet behavior and consequences
- Identify attitudes and behaviors that can be targeted to reduce likelihood of problematic internet behavior
- Identify and address obstacles to making positive change
- Identify alternative prosocial behaviors to achieve goals met by internet behavior

Guidance for Facilitator

These sessions are designed to develop an understanding of the antecedents and consequences of problematic internet behavior, which may or may not have also included offending. Examples include use of illegal pornography, sexual communication with minors, excessive pornography use, and excessive online sexual interactions with other adults (e.g., sex chats, fantasy forums, "hook-up" sites).

Each participant prepares analysis of internet behavior (index behavior) that led to offenses or that led to most negative consequences in the past (loss of relationship, conflict, loss of job). The analysis should include description of: the life circumstances in the three months preceding the index behavior; thoughts and feelings in the day preceding the index behavior; thoughts and feelings while engaging in index behavior; thoughts and feelings in day following index behavior; and negative consequences.
Introduce motivation-facilitation and good lives models as frameworks for thinking about problematic online behavior. The motivation-facilitation model addresses the sexual and nonsexual motivations for online behavior and the internal (e.g., offense-supportive attitudes and beliefs) and external facilitators (e.g., situational opportunities) that increase the likelihood of acting on that motivation. Good lives model addresses the needs met by problematic online behavior, strengths and concerns, and life goals.

Presentation of functional analysis typically takes one to two sessions per participant. Following the presentation, the facilitator and other participants should non-confrontationally question and discuss any contradictions in what person has presented or between what they describe and any collateral information.

Handout: Functional Analysis Chart

Key Steps in Problem Process	Situation	Thoughts	Feelings	Behavior

Handout: Online Decision Matrix

	Costs The negative consequences of online behavior	**Gains** The positive consequences of online behavior
SHORTER TERM		
LONGER TERM		

Sample Exercise:

What do we mean by a compulsive or addictive behavior? Could internet behavior have been compulsive or addictive in some ways? Why or why not?

Start by asking participants to identify examples of behaviors that might be compulsive, e.g., repeatedly cleaning, washing hands, checking, and then examples of behaviors that might be addictive, e.g., drinking, smoking. Flip chart the responses.

Ask participants to explain why they considered a behavior to be compulsive or addictive.

Then share DSM-like criteria for substance use disorder for discussion:

- Continued use despite negative personal consequences
- Repeatedly unable to carry out major obligations at work, school, or home due to use
- Recurrent use of even in physically hazardous situations
- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
- Withdrawal symptoms if stopped use
- Using greater amounts or using over a longer time period than intended
- Persistent desire or unsuccessful efforts to cut down or control use
- Spending a lot of time obtaining, using, or recovering from use
- Stopping or reducing important social, occupational, or recreational activities due to use
- Consistent use despite acknowledgment of persistent or recurrent problems as a result
- Craving or a strong desire to use

ONLINE IS REAL

Goals for Treatment Participants
• Understanding impact of rationalizations on likelihood of repeating behavior • Understanding how rationalizations relate to attitudes and values • Appreciate how online behavior can affect the "real world"

Guidance for Facilitator
Common rationalizations for problematic online behavior are that it is fantasy only, nobody was harmed, or that it was a substitute for more serious offending or problem behavior (e.g., using child pornography as a substitute for contact sexual offending, using mainstream pornography as a substitute for infidelity). This section addresses how these rationalizations can be obstacles to making positive change. This includes discussion of how children are exploited to create child pornography content, the vulnerability of minors who respond to online solicitations, and the potential negative effects of excessive pornography on relationship and sexual satisfaction. From croga.org: "Fantasies are not a problem unless they affect the things you care about in your life, like your family, friends, job, intimate and sexual relationships. There are many types of fantasies. The problematic ones are those that keep you busy for long periods of time and eventually increase the likelihood of the occurrence of illegal behavior." This section should also discuss the online disinhibition effect, a tendency to engage in behavior that would be less likely to occur offline in the presence of social cues from others and without a (false) sense of anonymity. Online disinhibition effect can be recognized in so-called trolling, rude/thoughtless responses to others, and thrill-seeking (e.g., looking for more extreme forms of pornography).

Handout: Fantasy Exercise

(to be completed as homework for discussion in group, for sexual and nonsexual fantasies. Examples of nonsexual fantasies might be about being powerful or wealthy, being very popular.)

What are fantasies? What purposes do they serve?

What triggers fantasies?

Why do you have fantasies?

What have you noticed about the sorts of moods or situations that prompt you to engage in fantasy?

Thinking of a sexual fantasy you had in the past month (you do not need to share the fantasy), list what triggered it and how you felt afterwards.

Thinking of a nonsexual fantasy you had in the past month (share this fantasy), list what triggered it and how you felt afterwards.